PRISON HEALTH SERVICES INCORPORATED

PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: Reed, Earnest BCDC#: 111914

1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.

2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.

3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.

4. I have had the opportunity to ask questions which have been answered to my satisfaction.

5. I understand there is no guarantee of success or permanence of the treatment.

Earnest Reed
Patient's Signature

2-17-04
Date

[signature]
Dentist's Signature

2-17-04
Date

PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

CONSENT TO TREAT FORM

(ROUTINE MEDICAL TREATMENT)

The inmate whose signature appears below does hereby grant authority to administer and perform routine examinations, treatments of minor illnesses and injuries, medications, and diagnostic procedures which may, during the course of the inmate's incarceration, be deemed advisable or necessary by physicians, dentists, registered nurses, or psychiatrists serving as contract providers. The individual reserves the right to refuse any medical or surgical treatment. Refusal must be documented in writing VIA release of responsibility. This consent also releases the medical record of the undersigned inmate in the whole or part to any outside consultant providing treatment or other services to the inmate on referral basis.

x Earnest Reed
Signature of Inmate

11-26-03
Date

Yolanda Hardy, LPN
Witness

11-26-03
Date

INMATE NAME (LAST, FIRST, MIDDLE)	ID #	DOB	RACE/SEX	FAC.
Reed, Ernest E. Jr.	111914	11-23-55	W/M	KCF

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Reed, Ernest (Print Name) 111914 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
(✓) Other describe A.B.D. Binder X 1

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Earnest Reed #111914 (Inmate) 7-7-05 (Date)

L. Ewing LPN (Witness) 7-7-05 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Reed Ernest	111914	11-23-55	W/M	Easterling

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Earnest Reed #111914
(Print Name) (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
(✓) Crutches
( ) Other describe Abdominal binder

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Earnest Reed _____
(Inmate) (Date)

S McKinnon 2-16-05
(Witness) (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Reed, Ernest	111914	11-23-55	W/M	Ewst

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Reed, Ernest (Print Name) 111914 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
( ) Eyeglasses
(X) Dentures F/p & denture cup
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
( ) Other describe _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

_____ (Inmate) Nov. 16, 2004 (Date)

_____ (Witness) Nov. 16, 2004 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Reed, Ernest	111914	11-23-55	W/M	East

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

PHS
PRISON HEALTH SERVICES INCORPORATED

DEPARTMENT OF CORRECTIONS

RECEIPT OF MEDICAL EQUIPMENT/APPLIANCE FORM

I, Ernest Reed (Print Name) 7632 111914 (Doc#)

acknowledge receipt of the following medical equipment or appliance:

( ) Splint
(X) Eyeglasses
( ) Dentures
( ) Prothesis describe _____
( ) Wheelchair
( ) Cane
( ) Crutches
( ) Other describe _____

I acknowledge that the equipment/appliance is functional for my use.

I also acknowledge the equipment/appliance is in good working condition.

Earnest Reed (Inmate) 6-28-04 (Date)

Y. Blackmon (Witness) 6-28-04 (Date)

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.
Reed Ernest	111914		WM	East

PHS-MD-70005 (White – Medical File, Yellow – Security Property Officer)

B 20

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-7-05

To: Doc

From: HCU

Inmate Name: REED, Ernest **ID#:** ~~#~~ 111914

The following action is recommended for medical reasons:

1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra until
5. Other

Comments:

(1) Bottom Bunk profile, No prolong standing, No heavy lifting x 6mo. 7/7/05 – 1/7/06

(2) Abd Binder x 6mo. 7/7/05 – 1/7/06

Earnest Reed #111914

Date: 7/7/05 **MD Signature:** Dr. Narbonne/05 **Time:** 2:35 p.m.

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 2/16/05

To: DOC

From: NCH

Inmate Name: Reed Earnest **ID#:** 111914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments: ABD Binder x Lemo.
Bottom Bunk, No prolonged standing
No heavy lifting x Lemo.
2/16/05 – 8/16/05

Date: 2/16/05 **MD Signature:** Danboure/SB **Time:** 12N

Earnest Reed

60418

7B39

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 11/10/04

To: DOC / Easterling

From: PHS / HCU

Inmate Name: Reed Earnest **ID#:** 111914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other Pick-up at. 5A. M or 5PM.

Comments:

Abdominal binder for Ventral hernia KOP

Bottom bunk, No prolonged standing,

No heavy lifting X 6 months 11/11/04 - 5/11/05.)

Earnest Reed

Date: 11/10/04 **MD Signature:** Darbouze / 2SLOTHPN **Time:** 700pm

60418

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-9-04

To: Doc

From: PHS

Inmate Name: Reed Earnest **ID#:** 111 914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

BS ✓ before Meals & afte meals X 3 days

7-11 3Am 78 6Am 91

7-12 3Am 86 6Am 86

7-13 3Am 102 6Am 88 at 940 A.M. CE

Date: 7-9-04 **MD Signature:** VOA Barbour/PA **Time:** 2:10 p

1/13/04

60418

Earnest Reed
111914

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 7-9-04

To: Doc

From: PHS

Inmate Name: Reed Earnest **ID#:** 111914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

① Kop Abd. binder X 6mos For Hernia

② Bottom Bunk Profile X 6mos

③ No Prolonged Standing - no heavy lifting X 6mos 7-9-04 → 1-9-05

Side Profile X 30 days 7-9-04 → 8-9-04

Date: 7-9-04 **MD Signature:** Von Dabouse/pa **Time:** 2:10 pm

Earnest Reed
#111914

60418

PHS
PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 5-11-04

73

To: Doc

From: HCU

Inmate Name: Reed, Ernest **ID#:** 111914 ~~111914~~

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

No Heavy Lifting x 6mo 5/11/04-11/11/04

Belt w/ Inguinal Hernia COP x 6mo. 5/11/04-11/11/04

Date: 5/11/04 **MD Signature:** Dr. Darbouze for Ewing **Time:** 1140 A.M.

Earnest Reed

PRISON HEALTH SERVICES INCORPORATED

SPECIAL NEEDS COMMUNICATION FORM

Date: 4-15-04

To: DOC

From: PHS

Inmate Name: Reed Earnest **ID#:** 111914

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Allow to Wear Cooper Bracket X 6mos to R arm

4-15-04 → 10-15-04

Date: 4-15-04 **MD Signature:** Von Anderson RN **Time:** 3pm

Earnest Reed #111914

60418

EASTERLING CORRECTIONAL FACILITY
PROCEDURE FOR ACCESS TO HEALTH CARE

Treatment for routine medical complaints and mental health complaints are processed through nurse screening seven days a week. Inmates must complete a sick-call screening form and turn this form into medical services for processing. You may obtain screening forms from any dorm cube or shift commander's office. you need to place the screening form in the locked box located at the dining hall. All health service requests are subject to a $3.00 co-pay being deducted form your PMOD account, depending on the nature of your request. Forms for segregation inmates will be collected by nursing personnel at 4:00am medication rounds. Doctor's clinic is held Monday through Friday excluding holidays or an unexpected emergency.

Inmates on sick-call screening must report for screening or sign a refusal of treatment form declining care. Screening for population is held on 1st shift at approximately 7:00am. Screening for segregation is held during the morning pill call rounds. Sick-call screening is held Sunday through Friday.

Pill call times for this institution are as follows:

POPULATION	DIABETIC	SEGREGATION
4:00am	3:00am	4:00am
9:00am	9:00am	10:00am
5:00pm	3:00pm	5:00pm

Medical request on weekends and holidays are reviewed. Any request for medical attention that cannot wait until the next sick-call clinic will be processed at that time. All other request will be held until regular Sunday through Friday sick call. Medical emergencies, such as those involving intense pain, potential life-threatening situations, or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest Correctional Officer of an emergency, so prompt access to health care is provided.

You are required to sign up for Dental sick call using the same procedure as medical sick call. Population and Segregation Dental Screenings are held weekly on Monday evenings at 1:00pm in the Health Care Unit. Follow-up care, if needed, is scheduled at this time. Emergency dental service is provided 24 hours a day with a dentist on call. Those not meeting scheduled appointments must sign a refusal of treatment form.

Your medical care is important. This is a joint effort between you and the Health Care Staff. Prescribed medications are to be picked up at pill-call, appointments kept, and education in services attended.

Comfort medications, such as cold medicine, headache medicines etc. are available in the canteen.

We ask that medical complaints against the Health Care Unit try and be resolved face to face. If concerns cannot be resolved verbally, a written complaint may be filed. You may get this form in the Health Care Unit. You must complete this form listing specifically the reason for dis-satisfaction, steps you have taken and the action requested to resolve the problem. Return this form to the Health Care Unit.

Inmate Signature	AIS#	Weight	Height	Date
X Earnest Reed	111914	177lb	5'10"	12/15/03

Witness	Date	Time
	12/15/03	9:00 pm

ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.

Ernest Reed
Inmate Signature
REED ERNEST

111914-C
AIS #

11-25-03
Date Signed

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

E A Stewlia
INSTITUTION

Reed, Ernest Jr. 11494 W/M
NAME **NUMBER** **R/S**

Lay-in for _____ **days from** _____ **to**
(date)

_____ **due to** _____
(date)

Bottom Bunk profile &
No heavy lifting profile
no greater than 10 lbs X

Instructions: 6 mo. 2/4/04 — 8/4/04

Failure to follow the directions above may result in a disciplinary.

_____ Earnest Reed
Date Issued **Signature**